Series on Upscaling Innovations in Reproductive Health, No. 8

Upscaling Reproductive Health Innovations:

Enhancing the Role of Civil Society

The International Council on Management of Population Programmes

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The *Series on Upscaling Innovations in Reproductive Health* aims at programme managers, policy-makers and others involved in population activities. The series documents innovative programmes and projects. Its purpose is to provide a better understanding of issues on service delivery and programme management for reproductive health care.

The editors for this issue are Jay Satia, Mukarram Chowdhury and Aun Ting Lim.

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Enhancing the Role of Civil Society

ICOMP

International Council on Management of Population Programmes

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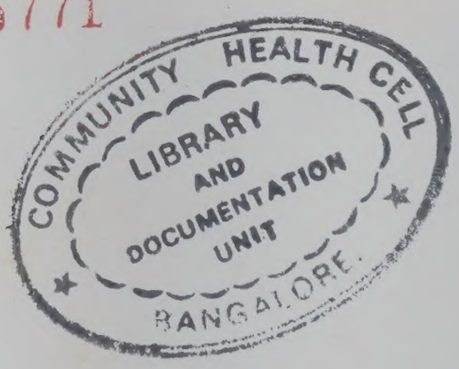

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Finally, it should be mentioned that it is difficult to render justice to many interesting papers and presentations when they are briefly summarised here. For this the authors are requested for their forbearance. These papers would appear in ICOMP publications. □

LIST OF ABBREVIATIONS

ARH	Adolescent Reproductive Health
ARHS	Adolescent Reproductive Health System
BCT	Bhoruka Charitable Trust
BRAC	Bangladesh Rural Advancement Committee
CAPS	Prenatal care centres
CBD	Community based distribution
CBO	Community based organisation
CFPA	China Family Planning Association
COLMEX	Colegio de Mexico
COPE	Client oriented and provider efficient
CORA	Centro de Orientacion para Adolescentes
CSO	Civil society organisation
DEMYSEX	Democracy and Sexuality Network
DFID	Department for International Development
DPF	Development of People's Foundation
ESP	Essential Service Package
FFPAM	Federation of Family Planning Associations of Malaysia
GO	Government organisation
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
IEC	Information, education and communication
IGDO	Integrated Gender and Development Office
IIHMR	Indian Institute of Health Management Research
IMIFAP	Mexican Family and Population Research Institute
IMSS	Mexican Institute for Social Security
IPPF	International Planned Parenthood Federation

ISSSTE	Ministry of Health and Social Security and Services Institute
IWHC	International Women's Health Coalition
KfW	Kreditanstalt fur Wiederaufbau
LGU	Local government unit
MAMANEH	Malaysian Association of Maternal and Neonatal Health
MEXFAM	Mexican Family Planning Foundation
MOHFW	Ministry of Health and Family Welfare
NCPFP	National Committee for Population and Family Planning
NFPDB	National Population and Family Development Board
NFVPP	National Family Violence Prevention Programme
NIPHP	National Integrated Population and Health Programme
PAISM	Women's Total Health Care Programme
POA	Programme of Action
PPHC	Progressive Primary Health Care
RH	Reproductive Health
RAFH	Center for Reproductive and Family Health
RCH	Reproductive and child health
RDP	Reconstruction and Development Programme
REACH	Reproductive, Educative And Community Health
REDESAUDE	Rede Nacional Feminista de Saude e Direitos Reproductivos
RRA	Reproductive Rights Alliance
RTI/STD	Reproductive tract infection/sexually transmitted disease
SIPAM	Women's Comprehensive Health
SMC	Social marketing company
SOMEDE	Mexican Demography Society
TFA	Target-free approach
UNAM	National Autonomous University of Mexico
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VINAFPA	Vietnam Family Planning Association

In pursuance of the International Conference on Population Development (ICPD), Programme of Action (POA), countries are now making efforts for strategic transition from Family Planning/Maternal Child Health programmes to comprehensive reproductive health (RH) programmes. To make the strategic transition effective, upscaling of reproductive health innovations in at least four areas is required:

- Expanding RH services,
- Effective implementation of adolescent/youth programmes,
- Enhancing gender responsiveness of programmes including male responsibility and involvement, and
- Improving quality of care.

All types of non-governmental organisations, including local women's groups, trade unions, co-operatives, youth programmes and religious groups, should be encouraged to become involved in the promotion of better reproductive health.

Para 7.9, ICPD POA

The ICPD POA has underscored the need to enhance the role of civil society in upscaling innovations in RH rights and RH care programmes (ICPD POA 7.9). The UNFPA expert consultative meeting[1] in April 1996 also concluded that "women's organisations and their diversity should be recognised as essential partners and their involvement in project and programme formulation institutionalised in the national processes." It also reinforced the ICPD POA's call for "genuine partnership between government and the private sector including NGOs."

What is Civil Society?

There are many forms of citizens' participation. The key forms of participation are (1) voluntary association, (2) social, (3) non-governmental organisations (NGOs), (4) foundations, and (5) traditional forms (eg. traditional social networks, religions).[2] The common term to capture the diverse expressions of citizen participation is *civil society.*

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[1] UNFPA, 1996, "Expert Consultation on Operationalising Reproductive Health Programmes," No. 37.

[2] Rubem César Fernandes. "Threads of Planetary Citizenship," in *Citizens Strengthening Global Civil Society.* Washington, USA: CIVICUS, 1994.

Civil society constituents are functioning intermediary organisations between the citizen and the state, and may include women's groups; national and local NGOs; private, non-profit sector[3]; professional groups/associations such as medical association, nurses/midwives association, population association; citizens groups; community groups; religious leaders and research organisations.

Tocqueville suggested civil society "as one of the mechanisms for preventing monopolies of state power." Hegel identified civil society as a dynamic organisation, which develops and changes historically.[4] The civil society democratises politics as it offers an option apart from the government. Therefore, civil society refers to self-organisation of citizens rather than of state or government. However, civil society is intertwined with the state because civil society organisations (CSOs) secure their own power as they negotiate and transact with the state. Thus, not only should each constituent of the civil society play its role, but it also needs to work in concert with others to upscale RH innovations.

"One of the mechanisms for preventing monopolies of state power."

Tocqueville on civil society

Civil Society: Its Role in Upscaling RH Innovations

Civil society has its legitimate role in both national RH policy formulation, and designing and implementation of RH programmes and pilot projects. There are many examples where CSOs have been instrumental in formulating RH policy in successful partnership with the public sector. CSOs have also been successfully designing and implementing programmes and pilot projects.

NGOs, as organised civil society constituent, have been implementing many successful collaborative programmes/ projects with the national governments in many countries across

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[3] Some definitions of civil society include the commercial private sector. In view of the diversity, we have treated commercial private sector as separate from other civil society organisations.

[4] Co, Edna A. "Reinterpreting Civil Society: The Context of the Philippine NGO Movement." *Trends and Traditions, Challenges and Choices: A Strategic Study of Philippine NGOs* (Alegre, Alan G., ed.). Quezon City: Ateneo Center for Social Policy and Public Affairs, 1996.

the three continents. There are distinct advantages of GO-NGO collaboration, some of which are:

1. Improved clients' access to service delivery,
2. Increased availability of services at the grassroots,
3. Increased interactions with the clients,
4. Improved information flow,
5. Enhanced cost-effectiveness,
6. Increased field testing facilities for new technologies,
7. Increased availability of trained manpower,
8. Improved accountability and transparency of NGOs,
9. Improved access of CSOs to policy formulation,
10. Increased CSOs' access to government specialist research facilities and expertise,
11. Improved quality of services due to healthy competition among the service providers,
12. Access to new technologies which would not have been possible otherwise to unorganised/un-coordinated RH service facilities and channels, and
13. Opportunities for CSOs to pass on technologies and models for replication or scaling up.

CSOs as intermediary organisations between governments/ donors and the citizens can facilitate communication between project beneficiaries and the government; articulation of community needs; community participation and group formation; training and building the capacity of community groups; and channelling of resources to the community level.

Civil society is crucial in effecting a strategic transition from current FP/MCH programmes to comprehensive RH programmes.

The role of civil society is crucial in effecting a strategic transition from current FP/MCH programmes to comprehensive RH programmes. It is imperative for the government and civil society to work more closely together with shared understanding on the concept, rationale and commitment to the RH rights as envisioned by the ICPD POA, and to work cohesively toward executing the programmes, thereby accelerating the implementation of the ICPD POA.

Initiating A Process To Promote Civil Society Role

To enhance the role of civil society, proactive actions are required. First, effective experiences need to be documented.

Second, these need to be shared and the knowledge base developed through cross-fertilisation of experiences. Third, this knowledge base needs to be translated in terms of frameworks and mechanisms for enhanced civil society role. Fourth, based on a situation review, the use of the framework and mechanisms needs to be promoted to enhance civil society role in upscaling RH innovations.

With these in mind, the International Council on Management of Population Programmes (ICOMP) organised a Ford Foundation supported seminar "Upscaling Reproductive Health Innovations: Enhancing the Role of Civil Society" in Genting Highlands, Malaysia from 29 June to 2 July 1998. This report summarises the main themes of the seminar.

Twenty-three participants (11 women, 12 men) from Africa (five participants), Latin America (three participants) and Asia (15 participants) took part in the seminar (see Annex 1). They represent a mix of government and civil society representatives including NGOs, religious leaders, women's health advocates, and researchers. In addition, there were representatives of The Ford Foundation, UNFPA and international organisations.

The seminar aimed to enhance the role of civil society in its collaboration with government to upscale RH innovations. To this end, the seminar design exposed nine country teams to the existing knowledge and experience on the best practices around the globe on increased utilisation of civil society role in RH innovations. It was expected that at the end of the seminar, the team members would be equipped to plan and initiate key activities which would upscale the RH innovations by enhancing the role of civil society in their respective countries.

Framework For Operationalising Civil Society Role

There are at least seven areas where government and civil society have their respective roles in moving the agenda of increased civil society role forward:

- Creating shared understanding,
- Sharing lessons on RH innovations and their synthesis,

A Seminar on Civil Society for RH

ICOMP invited 23 participants from Asia, Latin America and Africa to a seminar aimed at facilitating

- Sensitisation on the effective role of civil society in upscaling the RH innovations;
- Sharing of experiences of civil society role;
- Cross-fertilising knowledge and experiences across continents on promoting the role of civil society in the implementation of the ICPD POA for quality RH programmes globally;
- Developing framework and mechanisms for furthering the upscaling of RH innovations; and
- Encouraging participants to apply their newly acquired knowledge to their own country situation and take follow-up actions.

"ICPD POA cannot be efficiently met by national government of any size or economy unless there is clear understanding, cohesiveness and concerted efforts among the public sector, private business sector and civil society."

Dr. Raj Karim

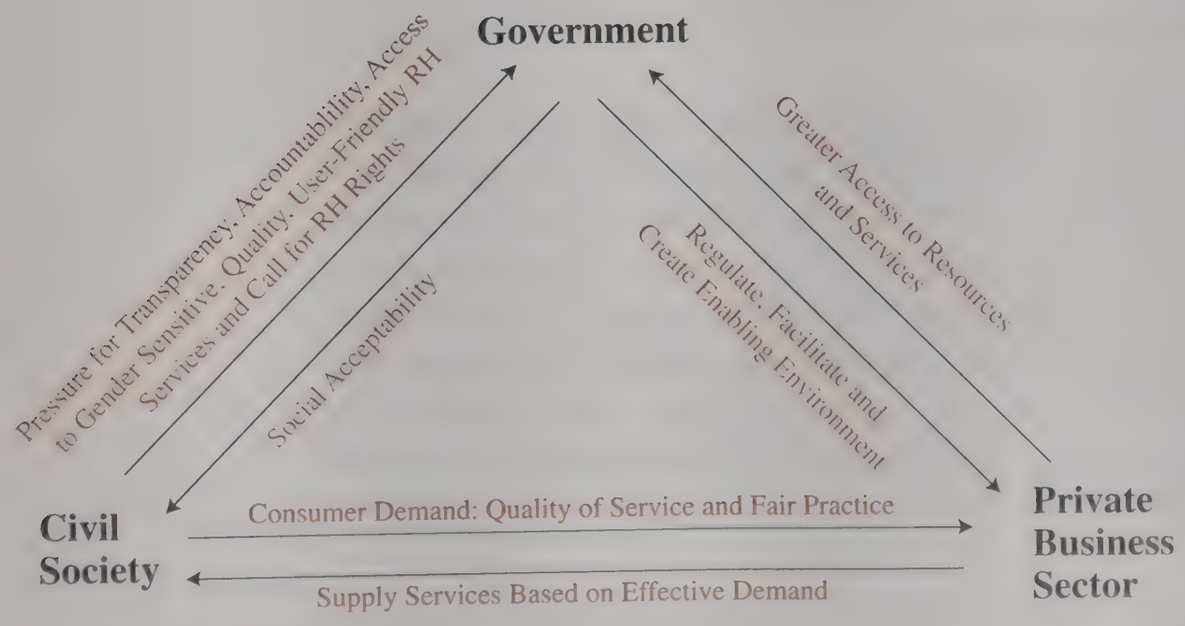
- Addressing social sensitivity,
- Promoting the role of women,
- Advocacy for developing an appropriate policy framework,
- Mobilising resources, and
- Operationalising the role of the private sector.

To accomplish these tasks, the intricate relationship between the two sectors: government and CSOs should be understood in the right perspective. The private business sector also has a distinct role in its transaction with the civil society and the government. The intricate relationship among the three sectors may be described in the framework below (Chart A).

This framework is based on the assumptions that the government, in an ideal situation, would work for the greater civil society approval and wider social acceptability for its activities. On the other hand, a well developed and well informed civil society will negotiate for greater transparency and accountability in government transactions, and demand for universal access to gender sensitive and user-friendly quality RH services from the respective government. The government would insist on the private sector to be innovative,

CHART A

Relationship Among Government, Private Business Sector and Civil Society



transparent, abide by the government rules and regulation, and bring positive impact on the national RH programme. The private sector expects the government to discharge its responsibility as regulator and facilitator in private sector friendly manner. It demands that the government create an enabling environment for the private sector RH services and products. The civil society expects the private sector to be gender sensitive, environment friendly and abide by the rules of fair practice. The private sector in turn wants the civil society to create favourable public opinion and create effective demand for quality RH services.

THEMES AND EXPERIENCES ON ROLE OF CIVIL SOCIETY IN UPSCALING RH INNOVATIONS

Six major themes guided the discussions on the role of civil society in upscaling RH innovations. In addition, the wealth of experiences represented by participants of the meeting as well as the outcome of the discussions pointed out another theme – Strategies for Organising: Sharing Experiences – which this section includes as the seventh theme.

Theme 1 Addressing Social Sensitivity and Creating Community Acceptability[5]

The Mexican Experience

The Mexican experience of joint projects between NGOs and the government on adolescent sexual and RH shows how the government can strengthen its capability to address social sensitivity and create community acceptability. The projects taken together cover all components of adolescent RH – counselling centres, peer educators, reaching out-of-school youth, and sex education in schools. The processes and results of some of the many successful collaborative RH projects between the government of Mexico and CSOs in Mexico are described here:

[5] Prepared by Yuriria Rodriguez Mtz., José A. Aguilar Gil, Gabriela Rodriguez R. and presented by Ms. Maria Eugenia Romero.

- Support from the Adolescent Counselling Centre (CORA) to some clinics and hospitals of the Ministry of Health and Social Security and Services Institute (ISSSTE):

  Since 1983, CORA sensitised the community to address sexuality issues during adolescence, tested action models for adolescent programmes, provided post-partum education for adolescent mothers at hospitals and organised youth promoters' networks and a theatre forum for young people in the city. The government has a programme called *El Buen Plan* aimed at promoting a culture of comprehensive health in adolescents and health service providers. Both CORA's model and its training experience have been used in this plan. CORA also trains programme personnel at the local level.

- The SEXUNAM project, implemented in collaboration with five NGOs and the health services system of the National Autonomous University of Mexico (UNAM):

  UNAM, in collaboration with NGOs working with women's reproductive and sexual health issues, is implementing the SEXUNAM project in seven upper higher education centres. Its objectives are training sexual and RH promoters, conducting dissemination and education activities, systematisation and evaluation of a methodology, and replication of this model in other settings within the country.

- The Mexican Social Security Institute (IMSS) and Mexican Family Planning Foundation (MEXFAM) Collaborative Agreement:

  MEXFAM's Gente Joven programme reaches youth at schools and in communities, gang members, street children and working children through activities including talks, street theatres and street film performances, largely through voluntary youth peer group. Through the IMSS-MEXFAM collaboration agreement, this programme has contributed to the transition process towards RH, incorporating the NGO work experiences with adolescents in the government sector.

- The relationship between the Democracy and Sexuality Network (DEMYSEX) and the Ministry of Public Education:

The DEMYSEX group was established in 1996 as a result of a meeting between some NGOs and the Ministry of Public Education. The organisations involved decided to join efforts to design a national sex education programme. As a strategic alliance, DEMYSEX promotes the communication and exchange of experiences among the organisations, to facilitate implementation of joint actions towards a positive vision of sexuality and advocacy of sexual and reproductive rights. It articulates technical effort from civil organisations for the design of a National Sex Education Plan.

These programmes/projects have contributed to the achievement of social awareness and community acceptance on issues such as adolescent/youths and male RH. These are some of the many examples of government and CSO collaboration and the enhancement of civil society role in upscaling RH innovations.

The participation of civil society has been helped by the Mexican government which is looking for new strategies to attain better and more significant achievements. In 1995, the Reproductive Health Inter-institutional group was created, with active support from the government of Mexico, to strengthen collaboration between government and the civil society for RH. The Ministry of Health is co-ordinating the implementation of the group recommendation. This inter-institutional working group, comprising various CSOs, has been one of the government strategies to increase the participation of the civil society, especially NGOs, experts, researchers and academicians.

Government agencies also conducted extensive surveys and research studies, and documented the wide support among the Mexican population for increased civil society participation in operationalisation of RH programmes at the national level. The official publication provides useful information to the civil society on the types and extent of RH needs of different cohorts of the population within different regions.

Non-government organisations such as MEXFAM, CORA, Women's Comprehensive Health (SIPAM), El Colegio de Mexico (COLMEX), the Mexican Demography Society (SOMEDE), and the Mexican Family and Population Research

Work by the RH Inter-institutional group helped the government create more relevant and efficient models and gave NGOs support and recognition for their achievements

Institute (IMIFAP) developed their own model programme and provided valuable insights into the regional variations on RH needs through their action research projects.

One of the activities of the inter-institutional group is the formulation of the 1995-2000 Reproductive Health and Family Planning Programme, which has adopted the strategy of increased collaboration among public and private sector institutions, as well as different CSOs. This collaboration has proved useful for the government in making their models more appropriate and efficient and has been of great benefit to the NGOs by offering them space and support for their models and recognition of their achievements.

Key Issues and Lessons

Looking at Mexico and other countries' experiences, many RH issues are sensitive: unwanted pregnancy and abortion, sexuality education both in school and out of school, STDs/HIV/AIDS, sexual orientation, gender, rape and violence, sex work, contraception, and female genital mutilation. The most sensitive target groups are: adolescents (Mexico, Malaysia, China and India), and unmarried adults (Vietnam and Malaysia).

The issues elaborated below on language, linkages with credible persons, consultation with stakeholders, use of peer educators and role models, appropriate information, education and communication (IEC), participatory approaches, sensitivity to environment and advocacy through research base require attention.

1. *Selecting the correct language for the issue to be tackled is important.* There are at least four aspects to this consideration:

    - *That the language chosen reflects the content of what it is trying to achieve.* In South Africa, the newly developed curriculum for teaching school children about sexuality and gender was called "life skills and sexuality training", hence expanding the areas covered to include issues of decision-making and negotiation, not previously considered within the school curriculum.

- *That the language chosen is sensitive to the cultural and political environment of the community and that it avoids stigmatisation that may pre-exist.* In Bangladesh, "menstrual regulation" is used to describe the therapeutic abortion programme, hence avoiding stigmatisation and legal conflict that the term "abortion" would evoke. In South Africa, the newly implemented abortion legislation was deliberately called the "Choice on Termination of Pregnancy Act", hence avoiding the stigma of the word "abortion" and introducing the concept of choice into the community.

- *That the language chosen is acceptable to the people at whom the intervention is aimed.* In many countries the term "sex worker" has replaced the term "prostitute," as women involved in the industry expressed their concerns, particularly in international HIV/AIDS forums, that their former title stigmatised them and hence was unacceptable.

2. *National policy is helpful, although not essential, to establish the underlying framework for action.* To this end, the lobbying of politicians is an essential tool where it is possible. In some countries, it is not possible to approach politicians and initiate discussions about policy. In these instances, there may be opportunities for CSOs to act on issues that are identified as priorities. Occasionally, examples set by "pilot" projects may get politicians to act on issues.

   In Uganda, where AIDS has been in epidemic proportions for several years, the president of the country set an example by openly discussing AIDS and HIV and implementing an open policy on the issue which paved the way for multimedia campaigns, condom distribution, service provision, schools programmes etc.

   In South Africa, an alliance of reproductive and women's health organisations employed a full-time parliamentary lobbyist (a lawyer) to lobby, argue with and support sympathetic politicians, over the issue of whether or not to legalise abortion.

3. *Win acceptance for the programmes being introduced.* Depending on the status of NGOs in any one setting,

different strategies may need to be employed in order to ensure credibility with policy-makers once programmes have been introduced. Many countries describe experiences of employing or in some way linking NGOs to appropriate academics, professionals or spokespersons in order to secure credibility. In the Mexican Youth Sexuality Programme in Schools, the NGO concerned linked up with recognised academics in order to secure political acceptance and credibility.

4. *Identify the appropriate target groups and any additional key stakeholders, and develop a comprehensive strategy to address their needs at the outset.* In the youth sexuality initiative in Mexico, where the aim was to introduce sexuality education into schools, youths, their teachers and parents were all consulted before the programme started.

5. *Use peer educators to gain access into groups otherwise not accessible.* Many countries have used peer educators as a way to access groups not easily reached with traditional information outlets. Several countries, including Mexico, South Africa and Zimbabwe, have developed youth peer education programmes for both in-school and out-of-school youths (PPASA, South Africa).In Brazil, where men's relationships with women were based on machismo, male mineworkers were used to influence and educate their colleagues on the question of condom use and safer sexual practices. In India, truck drivers were trained as peer educators in HIV/AIDS prevention campaigns.

6. *Use influential personalities as "Role Models."* Expanding from the idea of peer educators, some countries have used well known personalities to influence community behaviour, particularly where issues are sensitive. In Zimbabwe, well known artists and sports personalities promoted contraceptive use in a National Male Involvement Campaign Internationally, Ronaldo and Michael Jordan have (apparently) agreed to promote condom use and safer sex.

7. *Developing messages appropriate for the cultural, religious and political environment of the country.* In Mexico, it was appropriate for the schools' sexuality programme to talk

about sexuality and concepts of sexual pleasure. This would be taboo in Malaysia and in India.

8. *Community participatory approaches should be utilised when assessing the acceptability of RH programmes and interventions.* Lip service is often given, but often less is actually done. Such interventions should be strategically developed and seen through to the end. In the Swaasthya Project in New Delhi, mothers were consulted about the appropriate approach to be used when developing a sexuality education programme for their daughters. They empowered and authorised the NGO involved to undertake this activity on their behalf.

9. *Adopt a multimedia approach to publicise and educate the community.* In situations where the issue remains one that is sensitive to the community, politicians, or to other sectors of civil society (religious groups), the multimedia approach must be used with caution, and appropriate IEC campaigns developed. In Uganda, a multimedia approach was used to promote reproductive health messages. This included the radio, which has been shown to be particularly effective in many developing countries.

10. *Develop services that respond to the cultural and political environment, as well as to the needs of the community being targeted.* In the Shanghai Youth Programme, telephone hotlines were established in all involved communities. In Malaysia, youth centres have been established to counsel and support youth with information and education on sexuality. In the Malaysian context, however, the information would be aimed at encouraging youth to abstain from pre-marital sexual relationships. In an Indian school programme, an anonymous question box was introduced to allow young people to ask personal questions about their sexuality without fear of being identified.

11. *Undertake local and national research (backed up by international research) to argue the case for the policy or programme that is being advocated.* In Malaysia, the National Study of Reproductive Health and Sexuality of Adolescents (1996) has been used to persuade the government of the need to implement a RH service

package for adolescence and youth, within the cultural and religious sensitivities of the country. In South Africa, the National Incomplete Abortion Study, undertaken nationally in 1993, established that there was a serious problem with hospital admissions for unsafe abortion. This research was pivotal in changing abortion legislation.

Theme 2 Advocacy by an NGO Network[6]

HealthWatch, India

The HealthWatch experience demonstrates some success in continuing advocacy and, at the same time, highlights the need for civil society constituents to keep vigilant to achieve excellence and to keep government accountable and transparent.

In 1993, a core group facilitated regional consultations of NGOs, activists, demographers, women's health advocates and researchers to influence the government of India in its policy and programmes pertaining to population, health and women's empowerment. The pre-ICPD consultation created an opportunity for different constituencies to come together and arrive at a common understanding of the complex inter-linkages between population, poverty and development. They considered the alternative approaches to demographically driven, top-down approach to primary health care and family planning services in India.

HealthWatch facilitated India's transition to the target-free approach and RCH Programme.

In 1994, a network of voluntary organisations, researchers, development activists and concerned individuals formed a CSO called HealthWatch. The group, along with other CSO constituents and individual activists, continue to maintain pressure on the government to do away with the method-specific targets and to adopt a holistic RH approach.

Two years later, the government of India adopted the target-free approach (TFA) and abolished family planning,

[6] Prepared and presented by Prof. Vimala Ramachandran.

method-specific targets altogether. By January 1997, the government announced that it resolved to move from vertical family planning, child survival and safe motherhood programme to an integrated reproductive and child health (RCH) programme.

During the initial years of its existence, HealthWatch enjoyed favourable response from the government of India and donor community. HealthWatch initiated regional consultation on the preparation of the TFA manual. Members organised regional and state level meetings. The nationwide consultations were held between April 1996 and May 1997. On the request of the government of India, HealthWatch facilitated meetings to obtain feedback on the draft TFA manual of the government. Eight consultations were co-ordinated by nodal NGOs across the country and the concluding consultation was held in April 1997 in New Delhi. International donors and private foundations supported the consultations. The financial support for management of the activities came from a UN organisation. In addition, with the support from the World Bank, HealthWatch also discussed the proposed RCH approach during the regional consultations. HealthWatch also lobbied government officials, facilitated and organised orientation and training on the new approach and accessed and disseminated information. It exerted prodigious effort to maintain constant flow of information.

These consultations led to several recommendations to strengthen RCH service delivery and more specifically the grass-roots workers, the female auxiliary nurse- midwife (ANM) and the male multi-purpose workers. In addition, there was an overwhelming consensus that women's groups should be involved in community-based planning strategy and RCH programme. One of the dilemmas is that several government departments have already established women's groups for specific purposes, such as credit, health or nutrition. Catalyzing the formation of women's group or creating a village-based platform for women's health requires strategic planning and transparent and accountable management systems.

It is useful to distinguish between three types of NGOs: those working in family planning/health area, activist NGOs and other development NGOs. NGOs in India provide a very small proportion of the health care services. They are, therefore,

concerned about improving the quality and outreach of public services. The government is concerned about the role of activist NGOs such as HealthWatch. Therefore, the support from the government and donor community to HealthWatch has never been smooth. However, there are several areas of mutually beneficial collaboration between the government and NGOs. HealthWatch has initiated an internal dialogue on alternative advocacy strategies. It needs to work at different levels and different planes and maintain its own momentum to continue dialogue with the government in order to influence health policy for RH rights of women and men of India.

Key Issues and Lessons

Networking is important for information exchange and for capacity building.

1. *NGO networks can achieve better results if it includes diverse stakeholders.* In India, HealthWatch organised group meetings at state level and shared its experiences at regional meetings with the members of CSOs, comprising NGOs, professionals (both institutions and individuals), demographers, doctors, professional associations and female multi-purpose RH workers. These meetings were carefully planned and the meeting time, place, themes and issues were publicised well ahead of time. This advocacy NGO also publishes newsletters to keep the members updated on the emerging issues of interest for CSOs.

2. *Networking may be used as a process of sharing, advocacy, pressuring and harmonising.* Networking offers opportunity for sharing experiences and concerns, for promoting a cause by developing a common understanding. Strong networking among CSOs can exert pressure on the relevant entity to respond. Networking may also help in developing appropriate strategies and harmonising the activities.

3. *Networking encourages CSOs to adapt to the most appropriate practices.* If networking involves well represented CSOs and stakeholders, it provides an opportunity for adapting practices, for replication and upscaling. It can increase the knowledge base and improve resources, thereby strengthening CSOs and increases their eligibility to receive donor funding.

4. *Networking enhances stakeholders' participation.* It provides the opportunity for the members to exchange ideas among

themselves, improve their negotiating skills and develop smart partnership. Advocacy increases collaboration and co-ordination.

Theme 3 Involvement of Women's Organisations in National Policy Formulation and Implementation of RH Programme[7]

The Brazilian Experience

The Brazilian experience demonstrates the extent to which women's health organisations have managed to influence policy-making at national, state and municipal levels and in this way contributed to improved RH for women and girls. The experience also shows that despite limitations imposed by the political and economic situation, only the organisation of civil society as a source for social pressure will assure transparency and formulation of public policies and provision of adequate resources to benefit the poor and excluded population segments.

It was in 1970, amidst the struggle against the dictatorship, that the women's health movement started to gain momentum in Brazil as a result of its close connection with CSOs and the strengthening of the feminist movement. The first major success of women's health movement came in the era of democratisation in the 1980s, when a meeting in 1984 discussed the historic document, "The letter of Itapeceria," the Brazilian feminist proposal for higher priority to women's health from a perspective of total health care. This paved the way for dialogue between women's groups and the government on the implementation of the "The letter of Itapeceria," which led to the development of Women's Total Health Care Program (PAISM). This programme is designed by the Health Ministry with input from feminist leaders and women's organisations. However, given the complex nature of socio-economic and political dimension of the women's RH rights issues, the implementation of PAISM was not an easy task.

The women's health movement gained its strength from health issues, with the rise of several health groups and NGOs

[7] Prepared by Maria José de Oliveira Araújo and Wilza Vieira Villela; presented by Wilza Vieira Villela.

operating nationwide. The positive impact of the women's health movement is a result of a series of factors, including the strong network among the women's groups working on health issues such as sexual and reproductive rights and violence against women. In 1991, the Rede Nacional Feminista de Saude e Direitos Reprodutivos (REDESAUDE), a nationwide network comprising 60 NGOs and women's groups, 20 university groups working on gender and health issues, congresswomen, health and law professionals, and human rights activists was formed. REDESAUDE has representatives from the Ministry of Health, national and regional health councils and different government departments and agencies dealing with women's health issues. This has facilitated increased participation by the women's in the formulation, decision-making and implementation process of important policies on women's and adolescents' issues, strengthening the gender perspective, and helping to create a new vision and new health indicators.

CSO team efforts approached women's health holistically.

One of the priorities of REDESAUDE is participating at all legislative levels — national, state and municipal levels — to assure women and other social sectors the rights guaranteed by the constitution. It joined other women's groups in the ICPD and Beijing conference. The mobilisation of women's organisations around these conferences provided a deeper understanding of "total health" and "reproductive rights" and also intensified the dialogue between the government and women's groups. Implemented with local autonomy in eight Brazilian regions, the "Cairo Conference Proposal Monitoring Project," run by REDESAUDE, promoted the diagnosis of women's health conditions in the country using the ICPD's Programme of Action as a guide.

Societal control over formulation, planning, management, execution and evaluation of public policies contributes to greater benefits both to users, action planners and executives. It can take two forms: dialogue with the public sector for the formulation of policies, and pressure and monitoring to ensure implementation of such policies.

Key Issues and Lessons

1. *A holistic approach that ensures that women are not being discriminated against and are not deprived of their rights and opportunities is needed to improve women's status.* One way to this approach is to include women's agenda in national strategic planning. This agenda should call for reduction and elimination of gender subordination, for giving women equal opportunity as men to participate effectively in the community development and decision-making processes. Women should be educated and made aware of their rights and opportunities. They should be involved in the passing of laws, and in the implementation, controlling and the evaluation processes. Women's organisations should work toward nationwide networking.

2. *The progress towards women's empowerment accelerates if CSOs and the government work together as one team.* Strong leadership is required for the realisation of women's RH rights. This is possible when both CSOs and the government work together. To avoid conflicts, plans should be made with common consensus. The participation or involvement of the community comprising opinion leaders, teachers, CSOs and other stakeholders at state and local levels is important in ensuring coordinated programming for women and adolescents. This is all the more important when the state/local governments are not adhering to the central government's directives.

3. *The status of CSOs needs to be raised and mutual respect between the government and CSOs is necessary.* Brazil's REDESAUDE is accepted as the key women's organisation, a CSO with great powers in the formulation, planning, management, execution and evaluation of public policies. As such it is in a favourable position to advance women's health agenda.

4. *Language such as "partnership" may be articulated to suit the local needs and variations.* Sometimes using the word "partnership" to describe the working relationship between government and NGOs may not be acceptable to government. Thus, using other terms such as "strategic coalition," "alliance" or "collaboration" should be encouraged to facilitate collaboration between the two sectors. Another way to encourage collaboration is by using an issue-based or

task-oriented approach, where different parties will come together, develop a common vision and goals and then return to their own "world" after accomplishing their tasks.

Theme 4 Creating a Shared Understanding of Civil Society Role on Policy Framework/Formulation [8]

The South African Experience

Civil society in South Africa largely refers to the structures that South Africans have used to articulate their needs, aspirations and demands, taking the concrete form of non-government organisations (NGOs), community based organisations (CBOs) and mass based organisations.

A series of important activities jointly implemented by the civil society constituents and government led to a pro-people policy shift in reproductive health innovations in South Africa. Prior to the 1994 elections, the African National congress (ANC), the party in power, engaged grassroots communities in questions of policy through its branch structures. Women and men were consulted on priority health questions. As an election mandate, the government of South Africa formed a "Reproductive Health Steering Committee" co-ordinated by the Reproductive Health Research Unit. The committee undertook a national review of reproductive health services in consultation with the service providers, government and representatives of civil society and did rapid assessments of a range of services. The findings were disseminated in a meeting organised nationally and widely participated by the health service providers, managers, policy makers and NGOs. The review findings proposed the following interventions: 1) national integrated reproductive health services, 2) access to safe and legal abortion, 3) a national cervical screening and treatment programme, 4) a national STD and HIV programme and 5) a national youth reproductive health and sexuality programme. The study served as an important pointer towards the policy shift.

The Women's Health Project, an NGO, organised the Women's Health Policy Conference in December 1994. The conference used the output of regional workshops attended by

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[8] Prepared and presented by Ms. Audrey Elster.

the grassroots women organisations and documents developed by regional networks on issues such as maternal health, AIDS, violence against women, abortion, contraception and disability. The proceedings of the conference could be used as reference by policy makers.

Direct input from the communities was extremely relevant in contextualising the need for change, and the realities of those most vulnerable to unsafe abortion.

The South African constitution adopted in May 1996 specifies a number of reproductive rights, some of which are:

1. The equality clause outlaws discrimination on the grounds of pregnancy.

2. Freedom and security of the person includes the right to "make decision concerning reproduction" and "to security and control over one's body." These rights are widely interpreted as the individual's right to make a wide range of decision in relation to family planning, pre-natal care, safe delivery and post-natal care, prevention of and treatment for infertility, treatment of reproductive tract infections, sexually transmitted diseases and termination of pregnancy.

The Reconstruction and Development Program (RDP), initiated by the ANC, is an integrated, coherent socio-economic framework, which seeks to mobilise the people of South Africa and the resources of the country towards the final eradication of apartheid and building of a democratic, non-racist and non-sexist future. RDP's stated goals include free antenatal care, safe and supervised deliveries, paid maternity leave for six months and paternity leave for 10 days. These goals are intended to empower women and help them achieve their reproductive rights and health.

The ANC has ensured that at least one third of the elected parliamentarians are women. It has also established a gender commission which created a more favorable climate to lobby and advocate for the Choice on Termination of Pregnancy

Act 92 of 1996 which was passed by the Parliament on 31 October 1996. The collective voice of an alliance of NGOs, such as the Reproductive Rights Alliance (RRA) maximised the input of civil society by lobbying and providing direct technical support to government in the process. RRA's work included 1) identifying institutions/individuals who needed to be lobbied, 2) understanding the parliamentary process and rules, 3) establishing links with the Department of Health, 4) working with trade unions and political parties, 5) developing profiles of parliamentary committee members, 6) canvassing support of bureaucratic staff in parliament, 7) producing a bulletin "Barometer" to monitor the implementation of the Termination of Pregnancy Act.

RRA has been credited for creating knowledge base and conducting research so as to provide basis for policy advocacy and lobbying for positive change. RRA presented national research to parliament, and commissioned research as required on issues such as the implementation of the 1975 Abortion and Sterilisation Act. The 1994 RRA-sponsored National Incomplete Abortion Study was useful in providing detailed estimates of the extent of unsafe abortions, the racial aspect of access to legal abortions and the reasons for women having abortions. RRA gathered information from local research and service organisations on termination of pregnancy and compiled a set of 10 information packs which have been widely used by civil society organisations and government to provide accurate information in various subsequent education and training programs. A critical part of the RRA's strategy was to bring ordinary women into parliamentary hearings to describe their experience on abortion. The direct input from the communities was extremely relevant in contextualising the need for change, embedded in the discourse, and the realities of those most vulnerable to unsafe abortion.

Another example of civil society involvement in upscaling RH innovation at the national level is the work of the Planned Parenthood Association of South Africa (PPASA). PPASA has developed pilot projects in seven of the nine provinces which are introduced with the support of provincial health and education departments. The five PPASA programs are moving through the process of piloting to full scale implementation. The programs are 1) community based

distribution of oral contraceptives, contraceptives, condoms and reproductive health education; 2) adolescent reproductive health programs; 3) sexuality and life skills programs for teachers, parents and women; 4) the men as partners program; and 5) the values clarification program for health service providers.

South African non-profit private sector is privileged to work within a political context of transformation and democratisation. The resistance period under apartheid has led to a strong, vibrant civil society which has matured enough to constructively criticise and engage government on policy issues. Government departments have also actively engaged civil society organisations. The National Maternal, Child and Women's Health Directorate (MCWH) of the Department of Health adopted a policy of active involvement and ownership of reproductive health programs by community and women as a critical element of successful government programs. MCWH has convened a large national consultative meeting of health care providers and managers, academics, civil society organisations and inter-departmental colleagues to launch the drafting process of national policy on contraception in 1998.

The resistance period under apartheid led to a strong, vibrant civil society mature enough to criticise and engage government on policy issues.

However the challenges for civil society in South Africa is to sustain the success it has achieved so far through continuous learning and through providing support to the democratic government as well as serving as pressure points to ensure that the government delivers on its commitments.

Key Issues and Lessons Learnt

1. *Both formal as well as informal structures are needed for exchanging information, dissemination of knowledge and creation of common understanding.* Creation of NGO structures (alliance, organisations) formally constituted can represent collective views of NGOs on policy. Similarly, creation of government structures mandated or enabled

to dialogue with NGOs will facilitate dialogue among them. On the other hand, establishment of loose networks where there is no formal membership can facilitate informal exchange of ideas.

2. *NGOs need to adopt a variety of strategies to influence policy and programmes.* These would vary from dialogue in non-confrontational manner with the government to confronting and pushing the limits of government policies and programs. Civil society or NGOs need to identify potential areas of resistance to policy change, and engage appropriate structures proactively on these issues. NGOs, either as organisations or as identified individuals, can also act as consultants to the government to give requested or unprompted input on policy issues. However, the acceptability of NGOs is critical if policy is to be influenced and are appropriate leadership and backing are required to achieve this. NGOs can also carry out pilot projects to inform policy.

Theme 5 The Role of NGOs and Private Sector in Balanced, Quality Service Delivery Package[9]

The Bangladesh Experience

In Bangladesh, as of December 1995, there were a total of 1,328 NGOs of which 781 NGOs were involved in micro-credit, education, sanitation and nutrition improvement programmes while 547 NGOs work in health and the country's family planning. By December 1996, NGOs served one-fourth of the country's population in health and family planning through projects both in rural and urban areas. Another estimate places about 40 per cent of FP/MCH services were being provided by NGOs and social marketing companies (SMCs) jointly. Until the mid-1980s, the NGOs, by government policy, confined their work mainly to urban areas. With the change in government policy in the mid-1980s, NGOs have expanded their activities to rural areas. Currently, NGOs are estimated

[9] Prepared by Dr. Mohammad Alauddin and presented by Dr. Halida Hanum Akhter.

to cover 23 million of the population through a community-based distribution (CBD) system.

NGOs enjoy unique support from the government in different forms, including policy, administrative and legal support and favourable funding mechanism. The government also provides technical assistance to NGOs.

In 1978, the government enacted a law allowing NGOs to receive foreign funds to undertake family planning projects with appropriate approval from the government. The project approval process was previously cumbersome, lengthy and time consuming. To simplify the system and to get "one-stop services," NGOs successfully persuaded the government in establishing the NGO Affairs Bureau. The Bureau receives NGO project proposals and offers one-stop services for approval of the project within the deadline of 60 days. In addition, a working group comprising Government of Bangladesh (GOB) and NGO representatives have developed a guideline for GO-NGO collaboration in the field of FP-MCH.

Donor support and availability of funds to NGOs have contributed to the development of NGOs and provision of services to a large group of clientele. The key donors for NGO activities in FP/MCH activities are USAID, World Bank, Department for International Development (DFID) as co-donor of the Bank, and UNFPA. However, the development of NGOs was enhanced by the technical inputs provided by the intermediary NGOs of the donor agencies.

NGOs have contributed significantly to national programmes in family planning, child health and immunisation, safe motherhood and other RH issues:

1. Improving the quality of care:
   a. Development of quality assurance manual, field workers' guide, inter-personal communication curricula, service delivery guidelines on different family planning methods and RH services, documentation system for infection prevention,
   b. Introducing portable sterilisers for satellite clinics and portable incinerators for clinical waste disposal, and
   c. Competence-based training and technical assistance to

Poverty is the ultimate result of a combination of multiple factors such as lack of education, health, gender equity, and in particular, the lack of enabling environment which inhibits the participation of the poor in their own development and their ability to perform to their optimum potential. The civil society has its due role in empowering the poor to take an active part in their development.

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the government to adapt COPE, measurement of quality of care, etc.

2. Expansion of geographical coverage and service package,

3. Increasing programme sustainability and

4. Providing technical assistance and expertise toward making a transition from the family planning/MCH to comprehensive RH programme.

One major project in implementing the government's Health and Population Sector Strategy is the National Integrated Population and Health Programme (NIPHP), which will be implemented by NGOs and supported by USAID.

Despite impressive successes, NGOs face many challenges: weak networking among NGOs, substantial donor dependency, and the need to mobilise resources to serve the poor.

Key Issues and Lessons Learnt

1. *NGOs and the private sector can improve the quality, access and availability of the service delivery package.* RH packages should be developed for different target groups. Each target audience such as unmarried adolescents, sex workers has its own characteristics and needs. There are also ethnic groups and regional variations. These groups can be served better by NGOs and the private sector. Moreover, the contribution of NGOs and private sector increases resources in terms of training, service delivery facilities, human resources and materials.

2. *The government should set standards and create an enabling environment for growth of NGO and the private sector for Balanced Quality Service Delivery Package.* The government should assess its own strengths and weakness (comparative advantage) realistically. This exercise may be done through dialogue with CSOs or by carrying out a comparative advantage/needs assessment. The government and NGOs should see each other as playing complementary roles.

Tenure of government officials is often short; therefore continuing advocacy is important.

3. *Operationalising the POA through continuing advocacy is important.* There is still a great need for advocacy, appropriate policy framework and mechanism to operationalise the role of NGOs in implementing national RH programmes and ensuring RH rights to all women and men as envisioned in the POA. Many CSOs also did not participate in the ICPD process and need to be sensitised to ICPD POA. Advocacy in the public sector is also needed. The tenure of government officials is often short and new incumbents need to be oriented.

Theme 6 Creating a Shared Understanding of Civil Society Role in Policy Framework/Formulation on Gender Issues[10]

The Philippine Experience

Women's NGOs and people's organisations facilitated the consultations among different groups of diverse interests and enabled the groups to reach consensus on a RH framework in the 1990s. In 1991, the Local Government Code of Philippines was passed into law, which provided for decentralisation and greater participation of civil society stakeholders in governance. Advocacy and lobbying by women's NGOs and other civil society stakeholders contributed to the formulation of the "Philippine Plan for Gender Responsive Development," which calls for a development model that is equitable, sustainable, free from violence, respectful of human rights and dignities, supportive of self-determination of human potentials, participatory and empowering the nation.

Under the changed environment, the women NGOs remained vigilant in implementing the policy. Women's NGOs introduced a framework for women's health to include reproductive rights, sexuality and gender violence concerns.

The National Family Violence Prevention Programme (NFVPP) is one of the many programmes initiated by the women NGOs in the Philippines in order to achieve women's RH rights. It addresses family violence prevention in a comprehensive and

[10]Prepared and presented by Ms. Teresa Pacaba-Deriquito.

co-ordinated manner. NFVPP, a joint effort of NGOs, enjoys support from both the government and people's organisations and is currently engaged in the prevention, intervention and elimination of family violence. The basic programme components are: 1) policy advocacy and monitoring: legislative advocacy and community family violence prevention watch, 2) organising and social mobilisation through multi-agency action groups and "Voices of 2001: Breaking the Silence Campaign," and 3) public education and training.

Development of People's Foundation (DPF) is another CSO which has conducted community-based training, advocacy and research on RH in Davao City, Philippines. DPF has been able to 1) gather substantial amount of data for policy advocacy on reproductive health care strategy, 2) increase participatory and advocacy capacity of existing women's organisations in the local area, 3) establish continuous policy dialogue with local government units (LGUs) as development partners, 4) work towards behavioural change in men on increased women's participation in community building, 5) build self-esteem of local women, 6) politically empower the local populace to change their health conditions, and 7) include reproductive health care strategy in the local women's legislative agenda.

DPF has also been able to coordinate with various CSOs and government agencies towards a comprehensive, coordinated

National Family Violence Prevention Programme: Chronology of Events

• 1993	Plan initiated by the Women's Crisis Centre with the Senate Committee on Women and the Family.
• 1994-95	Regional consultations on Family Violence.
• 1995	National Conference on Family Violence.
• 1996	Institutional strengthening, partnership building and materials development.
• 1997	Conceptual clarifications, levelling-off strategies and formulation of principles of unity.
• 25 Nov 1997	Nationwide launching of International Day of Protest Against Violence.
• By year 2000	Collection of 2001 stories of women's experiences.

Women's Development Code of Davao City

In 1997, after a series of studies, consultations, and debates at the city council, the Women's Development Code of Davao City was made into law. The highlights of the Code are 1) adoption of gender responsive policies in all departments; 2) allocation of 30 percent of the official development assistance and 6 percent of Davao City's annual development fund for women and gender sensitive development projects; 3) creation of integrated gender and development office (IGDO); and 4) creation of councils for women at the district level. The CSOs started a multi-sectoral approach for monitoring the Women Development Code of Davao City, known as GenderWatch. It was the primary mover in developing recommendations for rules and regulations for implementing the Code. These were adopted by the council. It is currently developing a qualitative and quantitative set of indicators to monitor implementation and gender mainstreaming.

and community-based approach in responding to violence against women, a particular RH concern.

Key Issues and Lessons Learnt

Community-based consultations are important in creating a shared understanding. These can take the forms of gender sensitivity training, discussions with men, women and youth, and evoking experiences. Deep and shared understanding is vital because this could forestall misunderstanding or overlap of civil society's roles and governmental roles. Both men and women community leaders can play an important role in increasing awareness on their constituents' rights and opportunities.

Theme 7 Strategies for Organising: Sharing Experiences

From a Modest Relief Organisation to a major, Internationally Recognised Development NGO: BRAC, Bangladesh[11]

The Bangladesh Rural Advancement Committee (BRAC) came into being in 1972 in response to the humanitarian needs of refugees returning to their war ravaged country. Over

the past 26 years, BRAC has grown and matured into one of the largest development organisations in Bangladesh.

Programme Thrust and Strategy: BRAC calls for a holistic approach in poverty alleviation. Its activities focus primarily on women. Improvement of the health and nutritional status of women and children and sustaining health gains have become an integral part of BRAC's development focus.

BRAC usually carries out a pilot project to address a specific developmental problem and then upscales it based on its experiences. Its early efforts at building village organisations provides it with a network to upscale the projects.

Programme Scope: BRAC has been implementing a wide range of programmes which include

- Development of village organisations of the poor,
- Conscientisation and awareness building,
- Micro-credit,
- Health care,
- Training and capacity development and
- Provision of basic education for their children.

Programme Coverage and Achievements: With the help of nearly 20,000 full-time staff members in Bangladesh, BRAC has been implementing the above programmes. Some of the achievements are:

- Creation and sustenance of more than 65,000 village organisations with membership exceeding 2.3 million women.
- Disbursement of an equivalent of US$ 620 million as loans to poor women. Loan repayment rate has been consistently in excess of 98 per cent. The women have accumulated savings amounting to US$ 50 million.
- Operation of over 34,000 schools under BRAC's non-formal primary education programme. By design, at least 70 per cent of the children are girls. Currently 1.2 million children are covered by BRAC's education programme.

[11] Presented by Dr. F. H. Abed, Founder and Executive Director, BRAC.

- Implementation of health programme for a population of over 34 million in more than 25,000 villages. The programme includes basic and essential health care, reproductive health care and infectious disease control for all members of its village organisations. BRAC collaborates with the national government in the implementation of national programmes for nutrition, integrated health and family planning and disease control. It also provides family and sexual health information for unmarried adolescents, advice on contraception and spacing, pregnancy and post-partum care including safe delivery, RTI/STD treatment and control through syndromic management and HIV/AIDS awareness.
- Implementation of a pilot project on adolescent family life education on reproduction and sexuality.

BRAC disbursed an equivalent of US$620 million in loans to poor women with repayment rate exceeding 98 percent.

Lessons Learnt: BRAC found that increased access to income for women has resulted in improved health for women and children. Education provides women with information on how and where to access health services.

Philanthropy and Volunteerism : The Indian Experience[12]

This experience sharing focuses on two philanthropic activities in India: the Bhoruka Charitable Trust and the Indian Institute of Health Management Research.

Bhoruka Charitable Trust (BCT): The BCT, a service delivery organisation, is working in 200 villages in a remote semi-desert area of Rajasthan, India. At one time, the village schools faced a shortage of school teachers because they could not pay salaries. There were many unemployed educated youths who could serve as local school teachers in the villages. BCT agreed to pay US$20 per month as salary to each of these youths to work a supplementary teachers in the village schools, provided the villagers can organise, select the teacher and make the necessary payment out of BCT contribution. BCT deposits this money into the bank account operated by the village organisation. This encouraged the villagers to form organisations, get them registered and opened bank accounts. There are now 40 such registered organisations out of which 10 are getting government funding.

[12] Presented by Dr. Ashok Agarwal, philanthropist.

Lessons Learnt: Villagers can be organised in innovative ways to obtain external funding for greater access to education and increased employment opportunities for local unemployed educated youths

The Indian Institute of Health Management Research (IIHMR): The IIHMR, a private non-profit organisation, is the culmination of voluntary and philanthropy efforts of some visionaries. It focuses on research and training activities in health, family planning, and hospital management. It is also accredited as a WHO collaborating centre for primary health. It also provides support services to the government of India and USAID-supported NGOs. It has 30 support service organisations in three Indian states. It has provided technical assistance to 300 small organisations in capacity building in the area of management, proposal writing, and accounting.

Lessons Learnt:

Collaborative efforts among NGOs increased their human and other resources, and infrastructure facilities.

- Despite the contraction of donor's money globally, NGOs in India are getting an increased amount of money for medium to large sized projects. This is because NGOs have proved to be efficient and to be able to provide better quality of service with the same amount of money in the public sector.
- There is a problem of upscaling in terms of size of NGO activities. In response to this problem, the IIHMR has been implementing a 10 million German marks project sponsored by KfW through a consortium of five NGOs as an example to others.
- NGOs can work together and complement each other. The collaborative efforts among NGOs increased their resources, in terms of expertise, human resources and infrastructure facilities.
- The capacity building of existing organisations and institutions is a continuous process. Upscaling is possible if the existing activities are within the organisation's mandate and formulated carefully.

IPPF Experience in Upscaling RH Innovations[13]

The International Planned Parenthood Federation (IPPF) as the world's leading voluntary family health organisation, with member family planning associations (FPAs) in over 150 countries world-wide, believes that improving the sexual and

RH of people will help them to lead socially and economically productive lives and take greater control of their own destinies. IPPF's main strength is its unique federation of voluntary and autonomous FPAs which operate within their own cultural, social and legal settings and at the same time are linked to the federation through common standards and objectives.

Vision IPPF: In its strategic plan, Vision 2000, launched in 1992, IPPF identified six major challenges for the Federation and its FPAs. These are to: 1) meet the demand, an unmet need for family planning; 2) promote sexual and RH for all; 3) eliminate unsafe abortions; 4) take affirmative action to gain equity, equality and empowerment for women; 5) help young people understand their sexuality and to provide services that meet their demands; and 6) maintain the highest standards of care throughout the Federation.

Lessons Learnt: IPPF's experience shows that large NGOs with international structure and intermediary role can make a difference in RH innovations. IPPF's structure and international intermediary set-up with member NGO at country level allow it to address sensitive issues, such as unsafe abortion, unwanted pregnancies, etc., which governments may have difficulties dealing with. IPPF's consultative status with the UN and its network of members, together with its roles and functions which are readily accepted, make upscaling of RH innovations easier and more feasible.

Charter on Sexual and Reproductive Rights

Both IPPF and its member associations have carried out a multitude of activities to upscale RH innovations. One interesting example is upscaling through the use of IPPF's Sexual and Reproductive Rights Charter. This Charter, developed in 1995, identified twelve rights: rights to life; liberty and security of person; equality and freedom from all forms of discrimination; privacy; freedom of thought; information and education; choice whether to marry or not and to found and plan a family; decide whether or when to have children; health care and health protection; benefits of scientific progress; freedom of assembly and political participation; freedom from torture and ill treatment. Various FPAs have utilised the Charter for such activities as provision of legal advice, basis for advocacy, revision or drafting of new legislation and for dissemination.

Donor Experience In Upscaling RH Innovations[14]

The REACH Programme: UNFPA Country Office, Uganda, provided the financial assistance and technical support to the Sabiny Elders Association for implementation of a community-based Reproductive, Educative And Community Health (REACH) Programme. The programme aimed at discarding the female genital mutilation (FGM) in Kapachorwa district of Eastern Uganda. It has been successful in making a significant change in cultural behaviour of the community, and a large number of supporters of the practice have now declared openly their full rejection of it. Its success has earned the Association the United Nations Population Award 1998.

Critical Element for Success: The programme's success depended on many factors, but one critical contributor was the programme professionals' respect for the indigenous cultural value of marking the passage from girlhood to womanhood. The programme staff emphasised changing the way the value is practised rather than abolishing the value itself. The programme used the more neutral word "genital cutting" instead of "genital mutilation" and provided alternatives to cutting, including the sexual education programme to prepare the girl for womanhood.

Lessons Learnt:

- In the new paradigm shift from family planning to RH, CSOs have now greater flexibility of advocacy with the traditional leaders, community leaders, religious leaders, and the people who are at the community level and who make a difference in terms of the community.
- In addressing culturally sensitive issues such as FGM, managers/planners should design their programme in a way that separates values from practice. The professionals should understand and respect the culture, but put emphasis on the need to change the practice on the basis of knowledge, exposure, state of the art and technology.
- Instead of putting priority on selling "packages" to CSOs, donors should allow them to grow, expand and become empowered and independent.

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[13] Presented by Ms. Fauziah Varusay.

[14] Presented by Dr. Francois Farah.

Instead of selling "packages" to CSOs, donors should allow them to grow, expand and become empowered and independent.

- Both capacity and accountability (performance, credibility, legitimacy, negotiation with government) of CSOs need to be strengthened. CSOs need to draw legitimacy from both their constituencies and the state. CSOs need to specialise through constant review of their activities and adjustment of strategies.
- It is necessary to share information on civil society role in a much more systematic way. Donors can help in this process by funding a clearinghouse for this purpose.
- When donors reach an optimum point, donor fatigue sets in. At that point, CSOs need to be more innovative and either generate their own resources or shift priorities. Concrete, promising initiatives that are likely to show results are more likely to be supported by donors. Therefore, CSOs which have shown positive results in initiating and implementing innovative programmes/projects are better able to attract donor support.

COUNTRY EXPERIENCES AND PROPOSED ACTIONS

Each of the nine participating countries (Bangladesh, Brazil, China, India, Malaysia, Mexico, South Africa, Uganda and Vietnam) have been taking some effective steps in enhancing the civil society role. The civil society in these countries is actively participating in the different stages of national RH policy formulation and programme implementation. Of course, the intensity and the extent of CSOs' involvement vary from country to country, depending on the historical, political and cultural context of the country, and on the development of CSOs in general.

The main thrust for development of a country must come from within, where the poor and the deprived are empowered to alleviate their poverty, and as a result that of the nation."

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The country teams of the nine selected countries — comprising two to three members representing government and civil society — developed the respective country reports

depicting their own country situation in terms of the roles played by the civil society in upscaling RH innovations and their future role as seen by the respective governments *vis-à-vis* civil society.

Malaysia

Key Government Implementation Agency

The National Population and Family Development Board (NPFDB) is a major government body co-ordinating and implementing RH programmes. The key roles and responsibilities, and major accomplishments of NPFDB are:

- Formulating an integrated, multi-sectoral and multi-disciplinary programme strategy;
- Co-ordinating civil society to forge a closer relationship between the two sectors;
- Setting rules, regulations and procedures on RH matters in consultation with CSOs;
- Providing technical support to CSOs in the form of training and monitoring; and
- Compiling a directory of CSOs.

CSO Status

There are many CSOs in Malaysia. Some of the key CSOs include 1) Federation of Family Planning Associations of Malaysia (FFPAM), a major provider of RH/FP information and services; 2) Malaysian Association of Maternal and Neonatal Health (MAMANEH) which promotes safe motherhood; 3) Malaysian Council for Child Welfare which complements the government in enhancing the welfare and development of children; and. 4) National Council of Women Organisations which promotes women's rights. Influential political leaders are "patrons" of many CSOs.

Current Status of Collaboration between NPFDB and CSOs

Within the existing government mechanism, CSOs can bring up matters of concern and issues regarding RH for immediate attention to the government. Joint programmes between the government and CSOs are sometimes undertaken to address

specific issues. Joint programmes between the government and the CSOs help them limit the bureaucracies that would otherwise have affected the programme implementation process. Joint programmes also provide additional resources available to the implementing agencies. As a part of collaborative efforts, many studies, including the study on adolescent sexuality in Malaysia, have been undertaken by the government and CSOs to document the magnitude of the problem in RH rights and needs. The results from the recent study on adolescent sexuality are being used to formulate policies and implementation mechanisms to address issues related to adolescent RH. CSOs also have access to the public sector electronic media.

The NPFDB formulated an integrated, multi-sectoral, multi-disciplinary strategy for the implementation of its RH programme.

Major issues identified by both the government and CSOs for RH programmes include pre-marital sex among adolescents, domestic violence and sexual harassment.

Planned Follow-Up Actions

Malaysia

As a follow-up to the seminar, the country team observed that it would work to

- Further the role of CSOs by building capacity through training and continuous consultation, and increasing expertise in research, evaluation and monitoring mechanisms of CSO;
- Attract volunteers and instill a spirit of volunteerism among CSOs; and
- Improve the knowledge base by effective documentation of success stories.

Uganda

Favourable Policy and Mechanism for Government and CSO Collaboration

The RH programme is supported by the Constitution of Uganda which ensures affirmative action and equal opportunities. Other supportive instruments and policies

With support of CSOs, the government has designed and implemented a successful adolescent programme and reduced incidence of female genital mutilation.

include Population Policy, Decentralisation Policy, Gender Policy, Youth Policy, Adolescent Health Policy, Universal Primary Education, Poverty Eradication Plan, National Council of Children, National Drug Authority, Multi-sectoral Approach to HIV/AIDS Epidemic, and Policy on the Elderly.

CSOs in Uganda

The civil society in Uganda include, among others, advocacy sub-programme members, parliament members, health professionals, women's NGOs (eg. FOWODE and FIDA) cultural leaders, religious leaders (Moslem, Protestant and Catholic), youth leaders and youth-oriented organisations (eg. Naguru Teenage Centre, Uganda Medical Association and Uganda Women Doctors' Association).

Existing Collaborative Programme

Uganda is placing emphasis on the processes and approaches in implementation of its RH programme. In this orientation, RH programme has made room for consultative and consensus building among the key stakeholders. The country has been implementing culturally sensitive and community-based programmes realising that the RH programme is operating under certain constraints such as religious sensitivity and socio-cultural and political diversity.

One such example could be the implementation of an adolescent programme on RH. In this programme, active participation and involvement of key stakeholders including youth and CSOs, in different stages of programme formulation and implementation were consciously pursued. The process started with problem identification through research, followed by consensus building through a series of workshops attended by all key stakeholders including youth representatives from districts. Once the consensus was built, a plan of action was developed. The plan was then turned into a full program proposal. At this stage, relevant government representatives were involved through dialogue and negotiation. The process culminated in a programme owned by all.

Other examples include partnerships with religious leader, and parliamentarians on RH issues. The elders in the REACH programme have been involved in advocating for the

elimination of female circumcision through a culturally sensitive, community-based approach.

Planned Follow-Up Actions

Uganda

To strengthen further the civil society role, the participants from Uganda suggested these requisite actions:

- Sensitise civil society further on ICPD POA;
- Support NGOs to bridge gaps and weaknesses;
- Document processes and approaches that have led to success in various programmes and areas;
- Carry out an adolescent needs assessment; and
- Network among NGOs within the country and regionally.

Brazil

Existing Favourable Government Policy

The public health sector covers health needs of roughly 70 per cent of the total population. Post-ICPD, the Minister of Health declared women's health a priority. The ministry defined the reduction of preventable women's death as the main goal. Relevant government acts supportive of this goal seek to:

- Legalise sterilisation, forbidding its performance during caesarean section.
- Increase the payment for normal deliveries, in a bid to avoid unnecessary caesarean section.
- Authorise nurses/obstetricians to perform low risk deliveries.
- Launch a campaign against uterocervical cancer, including STD treatment using modified syndromic approach, condom distribution and counselling about safer sex, and performing pap smears for all women aged 35-49.
- Oblige public hospitals to perform abortion in the cases permitted by law.

CSOs and women's organisations' potential in HIV/AIDS prevention activities has yet to be tapped.

Government, Private Business Sector and CSO Collaboration

The AIDS Co-ordination Programme, in partnership with women's health programme, organised several local workshops involving professionals of programme and public health managers to formulate interventions such as STD/AIDS prevention, early diagnostic and follow-up of positive cases in primary health care. The National Medical Council has launched a campaign for normal deliveries, in partnership with some institutions of civil society and the Ministry of Health.

UNFPA and USAID fund some institutions working on population issues and RH, at governmental and non-governmental levels. NGOs used to be funded by private donors, like The Ford Foundation, MacArthur Foundation, ICCO, Global Fund, International Women's Health Coalition (IWHC), etc. Since 1994, the STD/AIDS Coordination has been funding NGOs' AIDS initiatives, selected by competition. There has been no tradition of private sector support in RH activities. On the other hand, since 1993, there has been a very successful partnership with AVON, a cosmetic manufacturer that employs many women to convene workshops on RH with them. The Ford Foundation and UNFPA fund REDESAUDE. The affiliate NGOs must search for funding on their own.

Planned Follow-Up Actions

Brazil

Follow-up actions would involve advocacy to convince the government of Brazil to

- Improve emergency contraception as a means to avoid some unwanted pregnancies;
- Sensitise men for increased condom use; and
- As women's NGOs in Brazil are not very active in HIV/AIDS activities, follow-up actions should aim at stimulating women's NGOs to undertake more projects on AIDS prevention for women (including gender sensitisation) as a matter of priority, both in epidemiological terms and funding terms.

India

Existing Policy and Programme

Post-ICPD, the government of India has begun implementing the comprehensive Reproductive and Child Health Programme. This programme envisages a much larger role for civil society constituents such as women's groups, other NGOs and local government institutions (*panchayati raj*).

Funding and Technical Support to CSOs

A review of the past experience identified some difficulty in utilising the potential of NGO involvement fully. The key implementation issues were 1) lack of flexibility in designing locally appropriate programme, 2) delays in fund release from the government, and 3) inadequate arrangement for evaluation of NGO programmes. To remedy these deficiencies, as well as to enhance NGO involvement, the Indian government has reorganised its NGO support scheme. This scheme recognises three levels of NGOs: small NGOs, mother NGOs and national NGOs. The scheme provides opportunities for "national level NGOs" to assist mother NGOs, which, in turn, would assist small NGOs. The funding support for this scheme has been increased to about four times its previous level and the number of NGOs involved is also expected to increase significantly.

India's reorganised NGO support scheme is expected to achieve greater flexibility in designing locally appropriate programme, quick fund transfer and greater transparency of NGO activities.

Planned Follow-Up Actions

India

The participants from India identified several activities which would strengthen CSO assistance to the government in implementing ICPD POA through support to the target-free approach and RCH Programme. CSOs with strong networking are needed at national, regional and grassroots. CSO institutions which can act as technical resource centres are needed to develop small CSOs, develop capacity and shoulder greater responsibility in implementing projects on a larger scale. The specific areas suggested by the participants include

- Enhancing capacity and capability of professional/academic/research bodies and voluntary organisations;
- Identifying organisations with specialised skills and experience to act as links between private institutes and the government; these tasks will include monitoring programme activities and establishing communication between project beneficiaries and the government, identifying community needs and community participation;

- Involving women's groups specialising in application of new FP methods/techniques;
- Enabling a collective civil society response to RH in an urban setting through 1) identifying potential civil society partners for Swaasthya, an NGO in New Delhi RH initiative, 2) creating a network of civil society partners, 3) identifying specific needs of the members to enable/ensure optimal response, and 4) exploring mechanisms for meeting the identified needs;
- Upscaling RH capacity building of NGOs; and
- Using IIHMR, as technical resource organisation, to initiate and implement RH programme at the grass-roots with 10-15 NGO partners.

Vietnam

Vietnam has supported CSO role in implementing its national programmes on quality of care, abortion and adolescent RH.

Existing RH Programme Focus

Both the Ministry of Health and the National Committee for Population and Family Planning (NCPFP) in Vietnam recognise the importance of incorporating RH into their respective programmes. After ICPD, a series of activities were conducted in Vietnam to promote the spirit of ICPD including holding workshops to disseminate the POA and the concept of RH. The major focus of the RH programme in Vietnam is to improve the quality of care for all RH services, reduce abortion rate, develop and implement obstetrics/gynaecological standards, ensure early detection of cervical and breast cancers, and provide comprehensive RH counseling.

Types of CSOs

Several CSOs are active in Vietnam, for instance,

- Fatherland Front has tried to mobilise support of influential people for Population and Sustainable Development;
- Vietnam Trade Union incorporates family planning IEC in all their activities to improve the quality of life;
- Vietnam Family Planning Association (VINAFPA), established in 1993, has branches in 30 out of a total of 61 provinces/cities to provide RH/FP services;
- Centre for Reproductive and Family Health (RAFH) carries out a variety of research in RH field;

- The National Committee for AIDS Prevention collaborates with many organisations; and
- Vietnam Peasants' Union carries out IEC for population and family planning for population living in rural areas.

Types of Collaborative RH Activities

The Vietnam Youth Union is implementing an adolescent/ youth RH programme which will focus on (1) education and orientation of healthy and safe sexual behaviour; (2) introduction and promotion of modern contraceptives; (3) prevention of early marriage; and (4) IEC on adolescent RH needs. Vietnam Women's Union and VINAFPA are also implementing adolescent RH activities.

Planned Follow-Up Activities

Vietnam

As a follow-up to the seminar, the participants from Vietnam would like to carry out the following activities:

- Report to the Council of Ministers, NCPFP and MOH about the outcome of the seminar;
- Sensitise the CSOs on enhancing the role of civil society in upscaling RH innovations;
- Implement collaborative project with CSOs in the field of IEC, service delivery and improvement of quality of care; and
- Provide input to the Council of Ministers in order to adopt policy to stimulate NGO activities and protect them as development partners.

Bangladesh

A notable feature of Bangladesh's RH programme is the collaboration between the government and the civil society in programme planning, formulation as well as implementation. NGOs in Bangladesh have been effectively working as facilitators between stakeholders and the government.

Stakeholder Consultations

Stakeholder consultations were a part of the development of the Health and Population Sector Strategy (HPSS). A broad

task force on stakeholder participation was constituted by the Ministry of Health and Family Welfare (MOHFW). A stakeholder mapping and analysis were conducted and three broad categories (primary or clients, secondary or providers and external groups[15]) were identified. the process identified gender and socio-economic equity as objectives. The consultative process included client and fieldworker consultations in selected areas using a participatory rural appraisal technique; and district-level workshops organised by MOHFW and facilitated by NGOs and women's organisations. The process developed a multi-pronged implementation strategy for the essential service package. Dialogues with professional associations and participation of stakeholders in the annual project review has been planned.

However, this process of collaboration needs to be carefully documented. Moreover, the RH programme in Bangladesh still has a long way to go to provide comprehensive RH services.

Planned Follow-Up Actions
Bangladesh

The Bangladesh country team identified serveral areas where it wanted to pursue follow-up actions:

- Orientation and sensitisation of newly recruited MOHFW government administration and programme officials on RH, rights and sexuality.
- Advocacy program on 1) adolescense including educating 10-24 year old male and female adolescents on RH issues and sexuality, and 2) male participation in improving RH and understanding their roles and responsibilities;
- Special service programmes on selected women's health including care and counselling of pre-menopausal women, infertility care and counselling.
- Evolving framework for implementation of RH innovations including adequate and detailed standards should be in place for proper implementation of Essential Service Package (ESP);
- Building capacity of CSOs; and
- Documentation of best practices, dissemination and sharing experiences.

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[15] The World Bank . *The World Bank Participation Source Book.* Washington D.C.: The World Bank, August 1996.

China

Favourable Environment for Increased Involvement of CSOs

In post-ICPD era, China has been making significant progress towards the transition from the national family planning programme to comprehensive RH programme. The activities include dissemination of information on different components of RH and implementation of different programmes. For example, the Family Planning Research Institute of Shanghai organised a seminar on social science in RH in 1994 with financial and technical assistance form the State Family Planning Commission, UNFPA and WHO. Yunnan RH Research Association and three other organisations organised a seminar on RTI in 1995 with funding from The Ford Foundation. Current programmes focus on at least eight key areas:

China has supported the role of CSO in disseminating information.

1. Informed choices of contraception,
2 Quality of care,
3. Male participation in family planning program,
4. Family planning services for the floating population
5. Reduction of abortion,
6. Maternal and child health care including breast-feeding and child immunisation,
7. AIDS and STDs, and
8. Adolescent/youth RH programme.

After the introduction of puberty education programme in primary and middle schools with the joint directives from the State Family Planning Commissions and State Education Commission in 1988, more than 20 provincial broadcasting stations have initiated special programmes on sex education.

CSOs' Collaboration with the Government of China

China has many large CSOs with well established organisational network. These CSOs have a large number of volunteers and members, which gives them the ability to gather information at the grass-roots level. These CSOs play the intermediary role between the people and the government. Some of the CSOs already are involved in implementing the national RH programme. For example, on behalf of the government of China, the China Family Planning Association (CFPA)

supervises the government field-workers and monitors the implementation of the RH programme at the grass-root level. By doing so, it assists the government in improving the work and upgrading the quality of service. Research, surveillance, information and education activities are carried out by both governments and NGOs nationwide.

Planned Follow-Up Actions

China

The China country team planned to initiate the following as a follow-up to the seminar:

- Work with the government in facilitating increased involvement of CSOs in policy formulation and implementation.
- Disseminate the experiences of the Pilot Project of Quality Services. These will cover the area of contraception, healthy child-bearing, childrearing and RH; inter-personal counselling and informed choice of contraceptive methods and follow-up visits; counselling on pre-marriage, post-marriage, pregnancy, post-natal care and treatment of infertility.
- Upscaling the co-ordination among NGOs and implementation of joint projects. The project will be in the area of base line surveys on the existing RH unmet need, implementation of project on adolescent sexual health and building capacity of NGOs by exposing them to successful RH programmes abroad through overseas study training.

South Africa

Policy and Programme

The new population policy of South Africa is a widely consulted paper which covers choice and human rights, sustainable integrated development, the status of women and literacy. This is a developmental and gender sensitive document. South African health policy is taking the pro-people approach and looking after the formation of district health system, expansion and formation of pre-primary health care services and integration of services. South Africa has adopted abortion policies known as the Termination of Pregnancy Act. In addition, the country will have a contraceptive policy within RH and adolescent RH policy. It includes STD/HIV/AIDS policy and is being implemented.

CSOs in South Africa

In South Africa, there are three basic civil society role players: 1) network of CSOs, 2) NGOs in service delivery and advocacy, and 3) NGOs in academic institutions which are providing advisory services and research on RH. RH NGOs are piloting models of best practices, providing adolescent RH services including life skills and sexuality education, and encouraging men's involvement in RH programmes. NGOs are also active in advocacy and lobbying the public and private business sector. Institutional NGOs have been conducting research and evaluation of RH programmes and projects. Planned Parenthood Association of South Africa (PPASA) and national Progressive Primary Health Care (PPHC) Network are two large networks. While PPASA is both an advocacy and service organisation, PPHC network does primarily advocacy work. National provincial governments are now interested to work with PPASA to look at upscaling PPASA's models of adolescent RH nationwide. The national AIDS programme has commissioned PPASA to expand the life skills and sexuality programme, which was previously piloted, to replicate it nationally. The government is also looking at multi-sectoral and inter-sectoral youth centres. The provincial government is interested to replicate the programme on improving the quality of care which is being pilot tested in the non-government sector.

The new population policy and health policy have created basic premises for active CSO participation in national policy formulation and implementation of pilot projects.

Planned Follow-Up Actions
South Africa

The participants from South Africa suggested the following actions:

- Building consensus between the relevant parties such as government and CSOs.
- Influence the government on policy formulation/institutional framework of partnership between the government and CSOs.
- Develop mechanisms for operationalisation of ICPD POA by both the government and CSOs.
- Conduct complete situational and stakeholders analysis, including the management and institutional capacity of CSOs, in terms of the issues of accountability, channelling of funds, needs assessment and reporting.
- Formulate mission statement and scope of work of CSOs.

Mexico

Existing Policy and Programme

The IMSS serves more than 52 per cent of Mexico's population for their RH services. Mexico has taken many positive actions after ICPD to transform its MCH/FP programme to a comprehensive RH programme. Currently, it provides services which include maternal health care, co-ordinated programme for adolescent care in collaboration with MEXFAM, family planning, mobile services, campaign to extend the RH information and service delivery to marginal urban populations in ten delegations. IMSS collaborates with other organisations in providing services on timely detection of women's neoplasias, menopause and climactic period, sexually transmitted diseases, HIV and AIDS, health for women at work, RH for farmers, prevention of disability and early diagnosis of congenital deficiencies.

Collaborative Activities

In order to achieve an integrated approach in diagnosis and treatment of high-risk pregnancies, considering both mother and child as a unit, a national programme called CAPS (Perinatal Care Centres) was initiated in 1998. On the basis of the existing infrastructure facilities and needs, the Mexican participants would like to implement a project on pre-natal care centre at IMSS. This would facilitate the availability of RH services in 200 hospitals in the country. These hospitals would need to be renovated and equipped to provide the comprehensive RH services and to become one-stop centres for RH services. CSOs would participate in the working group along with the government representatives in order to define the RH needs, design the programme, adopt the strategy and implement and monitor the programme. There would be defined areas for responsibility for CSOs as well as the government of Mexico.

Collaborative projects on adolescent health, maternal health care and information dissemination on STD/HIV prevention are examples of CSO-GO collaboration in Mexico.

Planned Follow-Up Actions
Mexico

The Mexican country team proposed to implement a RH programme for adolescents. This project would provide sex education to adolescents at clinics, train the health service providers and school teachers and work with the parents' association. This programme would also be a joint programme of the government of Mexico and CSOs. Representatives from both sectors would define, design, implement and monitor the programme.

ENHANCING THE ROLE OF CIVIL SOCIETY

CSOs have played an important role in RH programme, often in collaboration with government. For instance, various CSOs and the Government of Malaysia have undertaken a study on adolescents which is being utilised to formulate policy. The collaboration also pooled together resources to enable more ambitious undertaking than would otherwise have been possible had governments and CSOs operated independently.

In Uganda, elders have been involved in the implementation of an innovative and successful programme to eliminate female circumcision using a culturally sensitive community based approach. In Mexico, in order to bridge the gap between people's needs and government programmes, CSOs and private business sector served the RH needs of 48 per cent of the country's population. National Medical Council of Brazil in partnership with several CSOs and in collaboration with the Ministry of Health have launched a campaign for normal deliveries of babies in a country, where caesarean section is a common practice. In Bangladesh, NGOs provide support to the government through training on inter-personal communication and quality of care for the government service providers. CSOs also facilitated the stakeholders consultation which contributed to the development of the National Health and Population Sector Strategy adopted by the Government of Bangladesh.

Engagement of civil society can be a powerful force in bringing about political, economic and social changes that promote peace, social justice, and sustainable environment. These community groups, non-governmental organisations and other associations are essential to maintaining co-operation, trust, altruism and other values important to the health of all citizens of democratic societies and society as a whole.

Ms. Alexandrina B. Marcelo

CSOs sometimes carry out "watch" or "monitoring" function:

- In India under the NGO support scheme, "small NGOs" receive government fund from "national NGOs" through "mother NGOs," a step built in to help ensure that the government fund is effectively and efficiently utilised.
- In China many NGOs are asked to play an intermediary role between the people and the government, and even monitoring the government RH programme at the grass-root level.
- Set standards/modes: In South Africa, NGOs are piloting models of best practices, which include quality of care, adolescent RH and men's involvement in RH.

CSOs' Contributions to RH Programme

- Joint innovative programmes
- Bridging the gap between people's needs and government programmes
- Developing and using rights charters
- Provision of financial support to NGOs
- Supporting government programmes through training and other means
- Facilitating the national strategy/programme development

Premises and Principles of Government and CSOs' Collaboration

A premise behind the effort to enhance civil society role is that government and civil society working together can accelerate the pace of upscaling RH innovations and of transformation to comprehensive RH programmes. It also premised that if RH concerns are seen as important, then collaboration is more likely to happen and be sustained.

The paradigm shift arising from ICPD has underscored the need for CSOs to play a greater role. For this to occur, there is a need for conducive environment. The public sector can create this environment with more transparency, with a non-vindictive, unbiased, non-confrontational and supportive attitude.

There are still many gaps in the understanding and operationalisation of the ICPD POA. More effective collaboration through networking, information sharing, sharpening focus on RH concepts, programmes and operationalisation need to be carried out by governments, CSOs, and donor community. This calls for a search for effective mechanisms to enhance the role of civil society in upscaling the RH innovations.

The participants suggested two principles be used for effective collaboration between the government and the civil society. First, each must recognise that the other has certain comparative advantages and disadvantages. Second, each must build on the strengths of the other.

In formulating such a collaboration, it is important to understand the *context* in its various dimensions: political, social, policy environment, cultural homogeneity/diversity, priority accorded to RH, and status of civil society. These dimensions are critical in understanding CSOs' capacity, their needs for further capacity building, extent of their knowledge base, and their role in RH innovations. In many instances, CSOs are not aware of their rights and responsibilities, they do not have the requisite network with other CSOs and do not have the right type of resources to articulate their mission and goals. In addition, the existing political, social and policy environment might not allow CSOs to grow and contribute to the national RH policy and programmes.

Principles for Effective CSO-GO Collaboration

- Recognition that both government and CSOs have different comparative advantages
- Undertaking to build on the strengths of each partner

Opportunities And Constraints In Enhancing Civil Society Role

A window of opportunity for enhanced civil society role has currently emerged because of:

- ICPD and Beijing conferences
- Liberalisation of economies
- Process of political and social change

For instance, many countries have begun to allow NGOs a greater role after ICPD and the Beijing conferences. In this process, liberalisation of economies has also assisted in countries such as Vietnam and China. The process of political change in South Africa provided CSOs with a different challenge.

There are many constraints, however, in promoting and enhancing the civil society role. These include

- Inadequate efforts to create a shared understanding of RH perspectives and gender issues;
- Lack of a policy framework;
- Inadequate collaboration between government and NGOs;
- Lack of initiative on sharing lessons from RH innovative approaches;
- Weak role of CSOs other than NGOs;
- Cultural and social sensitivity, particularly in the area of adolescent/youth and sexually reproductive rights, and
- Weak role of women in designing and implementation of programme, particularly at the local implementation levels.

The above constraints need to be addressed by 1) putting mechanisms in place for civil society participation, 2) creating an appropriate RH policy/programme framework to facilitate CSOs' participation, and 3) enhancing capacity of government and CSOs to work together.

Policy/Programme Framework

Recognising that neither civil society nor the government is homogeneous in terms of attitudes, resources and perspectives on RH, there is a need to create a common vision. Creation of

common vision requires not only that the stakeholders cherish common values but also that they have information on the reality prevailing at the field level. A variety of data sources need to be utilised for this purpose and value clarification exercises can assist in this process.

Create Common Vision Through

- Feedback
- Study/Research
- Qualitative Data
- People's Voices
- Use of Available Data
- Dialogue/ Consultation
- Value Clarifications

CSOs can play a key role in creating a policy/programme framework through a variety of means such as

1. *Advocacy*: CSOs have played advocacy roles at local, regional, national and policy levels, and there is a continuing need for this role.

2. *Citizen Consultations*: Governments can obtain citizen feedback directly through mechanisms such as parliamentary hearings or indirectly through intermediary organisations as CSOs.

3. *Participation in Expert Groups*: CSO representatives in many countries participate in expert advisory groups formed by governments.

4. *Working with Local Government*: As many countries are decentralising their health programmes, CSOs would need to increasingly work with local governments.

In the process of participating in policy/programme formulation, the CSOs could adopt a variety of approaches such as:

1. *Confrontation.* CSOs have adopted this mode when there are irreconcilable, fundamental differences on policies.
2. *Pressure Groups.* Many CSOs have acted as pressure groups, particularly for women's empowerment and health issues.
3. *Consultative Process.* The government and CSOs can develop a working relationship and consult each other on their policies and programmes.
4. *"Smart" Partnerships.* Smart partnerships arise when CSOs and the government build on each other's strengths.

A variety of mechanisms have been used to enable, motivate and empower CSOs to perform their role:

- Innovative schemes of government

- NGO co-ordination committees
- Formal/Informal consultation
- Strengthening of capacity
- Identifying and building on comparative advantages
- Pro-active participation
- Networking (information and joint action)
- Developing policy framework
- Drawing up national guidelines

Some illustrative mechanisms to operationalise the civil society role are proposed in Table 1.

Table 1: Mechanisms to Operationalise Civil Society Role

Mechanism	Enhancing Gender Responsiveness	Improving Quality of Care	Adolescents' Reproductive Health
NGO groups/networks/ coalitions	Create community awareness; advocacy	Set standard	Advocacy for legislation and policy framework
Policy framework for civil society role and NGO co-ordinating committees	Work with national/local government to link with gender bureau	Participatory review of quality of care	Collaborative actions to implement programmes (eg. FLE and enforcement of regulations on child labour, child trafficking, etc.)
Mobilise private sector	Provide gender-responsive care & products	Peer pressure on providers. Monitor quality of care	Establish youth-friendly clinic
Project funding	Pilot projects	Fund quality improvement activities	Develop service delivery models
Citizen consultations	Advocacy for gender equity and equality	Feedback on quality of care	Create community acceptance
Mobilise community groups	Change social behaviour; male involvement in family responsibilities	Voice for quality of care	Youth groups to organise IEC/ service delivery

Challenges In Enhancing Civil Society Role

Despite a growing role for CSOs in almost all countries, many challenges remain:

- There is a continuing need for internalisation of RH. The government officials often have short tenures and the new incumbents may not be familiar with the ICPD POA. Similarly, many CSOs have not participated in the ICPD process.
- Stereotyping of civil society, such as "NGOs are dishonest," persist. It is important to have accurate information about civil society constituents.
- NGOs need to earn credibility through their performance and record of service if they are to be effective.
- Many government officials have a tendency to exercise control over NGOs, thus vitiating their strength of being innovative and flexible.
- Both government and NGOs need to increase human and organisational capacity to be able to work together and build on each others' comparative advantages. Both government and CSOs need to become more willing to share power and work as partners, at least on issues they agree on.
- Cohesion and commitment among CSOs need to be sustained. Often CSOs can be mobilised on an issue but sustaining the enthusiasm poses a problem. For effective, collective action, some cohesion among CSOs is also necessary.
- CSOs suffer from resource shortages, and unlike the government or commercial sector, they do not have an assured source of funds. Normally CSOs may earn income from four sources: 1) earned income from fees and other self-generated income and investment earnings, 2) contributions from domestic foundations, business, and individuals, 3) domestic government subsidies/grants and 4) foreign aid. With the exception of earned income, the other sources of income are not on a continuous basis.
- Many CSOs are donor dependent. They need to reduce this dependency through innovative means of resource mobilisation. The CSOs can improve their resource base by generating new wealth through market-based approaches and capitalising on non-financial resources.

Challenges

- Continuing need for internalisation of RH
- Stereotyping of civil society
- Enhancing NGO credibility
- Government tendency to exercise control over NGOs
- Need to enhance government and NGO capacity to work together and to share power
- Sustaining cohesion and commitment among CSOs
- Overcoming CSOs' resource shortages
- Reduce CSOs' donor dependency

Enhancing Civil Society Role In Upscaling RH Innovations

The following are pointers for enhancing civil society role:

- Create a knowledge base through 1) documentation of the best practices available in the countries, 2) NGO networking/coalition building, 3) government policy framework and NGO co-ordinating committees, 4) pilot projects by NGOs and government learning through them, 5) citizen consultations, and 6) project funding by donors and government .
- Advocate for creating a common vision in the countries and catalysing civil society role, particularly for enhancing gender responsiveness, improving quality of care, and promoting adolescent RH.
- Capacity building of participatory CSOs through 1) identifying participatory CSOs[16], 2) supporting the participatory process, 3) addressing the question of scale, 4) enhancing NGO capacity, 5) strengthening CSO-government linkages, 6) networking of the CSO leaders, and 7) resource mobilisation.

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[16]The World Bank. *The World Bank Participation Source Book.* Washington, D.C.: The World Bank, August 1996.

- Sustaining civil society necessitates that, in addition to maintaining financial viability, that the CSOs learn to survive transitions, learn to adapt, remain dynamic, and set clear mission and strategies.

Elements for Enhancing CSO Role in Upscaling RH Innovations

- Create knowledge base through documentation of success stories, experience sharing and establishing CSOs as legitimate counterpart to the government;
- Build coalition, networking and advocacy among the CSOs;
- Strengthen the programme and management capacity of CSOs; and
- Ensure higher degree of sustainability for CSOs.

A Menu of Actions to Enhance Civil Society Role

The seminar participants identified actions they intend to take after returning to their countries. While specific actions for each country differ, taken together they provide a menu of possible actions to enhance civil society role in upscaling RH innovations.

1. Sensitisation to "ICPD POA and Civil Society Role"
   - Sensitisation of government officials
   - Sensitisation of civil society constituents

2. Promoting Civil Society Role
   - Mapping and communicating existing potential
   - Promoting volunteerism
   - Networking of NGOs
   - Documenting best-practices/inventories/experiences

3. Advocacy by Civil Society
   - On adolescent RH
   - On gender and male responsibility

4. Capacity Building
   - Of NGOs to effectively perform their role

5. Creating an Enabling Environment
   - Building consensus on civil society role
   - Evolving framework for civil society-government actions
   - Strengthening communication/dialogue/linkages between CSOs and government
   - Upscaling co-ordination arrangements
   - Specifying eligibility criteria for NGOs and mechanisms for government support
   - Formulating policy/guidelines for CSO activities and protecting them

6. Policies and Programming
   - Feedback for policy formulation
   - Pilot projects for feedback to governments
   - Models for special RH services
   - CSO representatives on programme advisory committees

Conclusion

The output of the seminar will be used as input for formulating country level initiatives in promoting role of civil society in upscaling reproductive health innovations and, therefore, ICOMP has a crucial role to play in providing the necessary technical assistance and follow-up actions.

Ambassador
S. B. A. Bullut

Citizens benefit from the participation of civil society when it plays a role in democratisation of politics and provides options not offered by the state. From this perspective, civil society has a critical role to play in RH innovations, in terms of successful policy formulation and programme/project implementation on family planning, contraceptive service delivery, child immunisation, and in creating awareness among the policy-makers in adopting the ICPD POA incorporating universal RH rights for women and men. National governments are committed to the POA, and by endorsing the POA, they are also committed to enhance the role of the civil society in upscaling the RH innovations. It has been learnt that the CSOs in all the participating countries have already been active, and in many instances have been successful in achieving their desired goal.

It has also been learnt that the most effective CSOs in RH innovations are those which are well informed on their roles and responsibilities. This is also true for the well informed government policy-makers and managers who have been most successful in getting the best out of CSOs in making the paradigm shift from family planning to RH in their own countries. Therefore, both the civil society constituents and the relevant government officials/ managers should be sensitised on the ICPD POA and the role of civil society in RH innovations. The civil society needs effective

support from the national government in each country in the interest of expanding RH services, of effectively implementing adolescent/youth programmes, enhancing gender responsiveness of programmes including male responsibility, and improving of quality of care in each country. Therefore, each and every national government should create an enabling environment for supporting the growth of civil society in terms of their capacity building, increased participatory skills, and effective intermediary organisation between the members and the state.

In order to utilise its full potentiality, civil society needs support from the donors in building a knowledge base which is important for the CSOs, community members as well as the government policy-makers/programme managers and programme implementors. CSOs need appropriate funding and technical assistance in advocacy, capacity building and implementing pilot model projects for wider replications by the national and state governments.□

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SEMINAR PROGRAMME

June 29, 1998		**Chairperson**
8:30	Arrival of Participants	
9:00	Registration	
10:00 -11:00	Opening Session • Welcome Address and Purpose of the Seminar: Prof. Jay Satia • Remarks of The Ford Foundation Representative: Ms. Reena Marcelo • Key-Note Speech: Dr. F. H. Abed • Opening Address and Opening of the Seminar: Dr. Raj Karim • Chairperson's Remarks: Amb. S. B. A. Bullut • Note of Thanks	Amb. S. B. A. Bullut
11:00 - 11:30	Tea	
11:30 - 12:30	Introduction to Workshop Participants' Introduction Background Paper: Mr. Mukarram H. Chowdhury	Dr. Raj Karim
12:30 - 2:00	Lunch	
2:00 - 3:30	Presentation of Theme Papers: • Addressing Social Sensitivity: Creating Community Acceptability, Mexican Experience Ms. Maria Eugenia Romero • Advocacy by a NGO Network HEALTHWATCH Experience in India: Prof. Vimala Ramachandran. • Involvement of Women's Organization in National Policy Formulation and Implementation of National RH Program: Brazil Experience Dra. Wilza Vieira Villela	Dr. Atiqur Rahman Khan

		Chairperson
3:30 - 3:45	Tea	
3:45 - 4:15	• Creating a Shared Understanding of Civil Society Role: Policy Framework/ Formulation, South African Experience Ms. Audrey Elster	
4:15 - 5:15	Group Work on Theme Presentation	
June 30, 1998		
9:00 - 10:00	Presentation of Theme Paper Continues • The Role of NGOs and Private Sector in Balanced Quality Service Delivery Package: Bangladesh Experience Dr. Mohammad Alauddin/ Dr. Halida Hanum Akhter • Creating a Shared Understanding of Civil Society Role: Policy Framework/ Formulation in Gender Issue, Philippine Experience Ms. Tess Pacaba	Dr. Ashok Agarwal
10:00 - 10:15	Tea	
10:15 - 11:15	Experience Sharing • Philanthropy and Volunteerism: Indian Experience: Dr. Ashok Agarwal • Donor Experience in Upscaling RH Innovations: UNFPA Experience with REACH Program in Uganda: Dr. Francois Farah • IPPF Experience Sharing on Upscaling RH Innovations: Ms. Fauziah Varusay	Mr. Shirajul Islam
11:15 -1:00	Group Work on Theme Presentations and Experience Sharing	
1:00 - 2:00	Lunch	
2:00 - 2:45	Group Presentation	Dr. Helen Rees

		Chairperson
2:45 - 4:15	Presentation of Country Papers • China: Professor Zhou Jianping • South Africa: Dr. Helen Rees • India: Mr. P. K. Saha	Dr. Ramon A. Ruiz-Tapia
4:15 - 4:30	Tea	
4:30 - 5:30	Group Work on Country Presentations	
July 1, 1998		
8:30 - 10:00	Presentation of Country Paper Continues • Mexico: Dr. Ramon A. Ruiz-Tapia • Uganda: Dr. Jotham Musinguzi • Malaysia: Ms. Anjli Doshi	Mr. P. K. Saha
10:00 - 10:15	Tea	
10:15 - 11:15	Group Work on Country Papers	
11:15 - 12:45	Country Paper Presentation Continues • Bangladesh: Mr. Shirajul Islam • Vietnam: Dr. Nguyen Thien Truong • Brazil: Dra. Wilza Vieira Villela	Dr. Jotham Musinguzi
12:45 - 2:00	Lunch	
2:00 - 2:45	Group Work on Country Papers	
2:45 - 3:45	Group Presentation on the "Best Practices to Enhance Civil Society Role in Upscaling RH Innovations: Country Experience"	Dr. Halida Hanum Akhter
3:45 - 4:00	Tea	
4:00 - 5:30	Country Team to Develop Action Plans	

		Chairperson
July 2, 1998		
8:30 - 10:30	Presentation of Country Action Plan	Dr. Ayse Akin
10:30 - 10:40	Tea	
10:40 - 11:30	"Where To Go From Here" - Remarks 1. Dr. Atiqur Rahman Khan 2. Dr. Francois Farah 3. Ms. Reena Marcelo 4. Prof. Zhou Jianping 5. Prof. Le Dien Hong 6. Prof. Jay Satia	Amb. S. B. A. Bullut
11:30 -12:00	Concluding Session	
12:00 -1:30	Lunch	
1:30	Depart for Kuala Lumpur	

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